**MEDICAL BOARD STAFF REPORT**

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| DATE REPORT ISSUED: | July 8, 2008 |
| DEPARTMENT: | Executive Office |
| SUBJECT: | SB 376/2003: Direct Employment of Physicians – Report to the Legislature |
| STAFF CONTACT: | Kevin A. Schunke |

REQUESTED ACTION:

Appoint one or two Board members who will work with staff to finalize a report to the Legislature, which is due by October 1, 2008.

STAFF RECOMMENDATION:

Senate Bill 376 (Chapter 411, Statutes of 2003) was authored by Senator Wesley Chesbro and signed into law by the Governor. Under that law, which took effect on January 1, 2004, the Board was directed to establish a pilot program (pilot) to provide for the direct employment of physicians by qualified district hospitals. The pilot is set to expire on January 1, 2011.

The board shall report to the Legislature not later than October 1, 2008, on the evaluation of the effectiveness of the pilot project in improving access to healthcare in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine.

Since the next meeting of the full Board will be after the report's due date to the Legislature, staff requests the appointment of one or two Board members to work with staff to finalize the report (draft copy attached) and grant approval of the report on behalf of the Board.

EXECUTIVE SUMMARY:

Attached is a draft version of the report. Staff welcomes input from the full Board and looks forward to fine-tuning the final document with the Board member(s) appointed to assist.

FISCAL CONSIDERATIONS:

None. Creation of the report will accomplished within existing resources.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

While staff has reported to the Board on the progress of the program, no previous action has been required by the Board.

MEDICAL BOARD OF CALIFORNIA
Executive Office

# SB 376: Direct Employment of Physicians

# DRAFT Report to the Legislature

## Executive Summary

The Medical Board of California (Board) is required to submit a report to the Legislature by October 1, 2008, offering an evaluation of a pilot program (pilot) which allowed for the direct employment of physicians by qualified hospital districts. The purpose of the pilot was to improve access to healthcare in rural and medically underserved areas, and the evaluation is to address not only access to care issues, but also the pilot's impact on consumer protection as it relates to intrusions into the practice of medicine.

The pilot was promptly implemented by the Board after the bill was signed by the Governor and operational by the time the provisions of the bill became effective. However, the response from qualified district hospitals was limited to the extent that the Board was hindered in making a full evaluation.

Therefore, the Medical Board believes there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians can be made.

## History and Background

In California, the practice of medicine is governed by the Medical Practice Act. Specifically, Business and Professions Code (B&P) Section 2052 states that practicing medicine without a valid license is unlawful. Licenses are issued only to individuals.

Further, B&P Sections 2400, et seq., commonly referred to as the "Corporate Practice of Medicine", generally prohibits corporations or other entities that are not owned by physicians or other allied health professionals from practicing medicine, to ensure that lay persons are not influencing the professional judgment and practice of medicine by physicians.

Today, most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, narcotic treatment programs, and certain non-profit organizations.

While some states do not enforce their own statutes which ban the corporate practice of medicine, California is more rigorous than most states in this prohibition and is one of only a few states that prohibits the employment of physicians by hospitals (other states: Colorado, Iowa,

Ohio, and Texas). This concept is not specifically written in law; however, the California Attorney General opined in 1971 that hospitals could not practice medicine and therefore could not employ physicians, even for the purpose of serving in emergency rooms.

The responsibility for licensing physicians and for enforcing California's Corporate Practice of Medicine provisions is within the scope of the Medical Board of California (Board).

Senate Bill 376 (Chapter 411, Statutes of 2003) was authored by Senator Wesley Chesbro and signed into law by the Governor. Under that law, which took effect on January 1, 2004, the Board was directed to establish a pilot to provide for the direct employment of physicians by qualified district hospitals. The pilot is set to expire on January 1, 2011.

This bill was sponsored by the Association of California Healthcare Districts (ACHD) to enable qualified district hospitals to recruit, hire, and employ physicians as full-time paid staff in a rural or underserved community meeting the specified criteria. A goal of the legislation was to improve the ability of district hospitals to attract physicians to rural and underserved communities.

**Specific requirements of the SB 376 Pilot**

- Provides for the direct employment of a total of 20 physicians in California by qualified district hospitals.
- Limits the total number of physicians and surgeons employed by a qualified district hospital to no more than two at a time.
- A "qualified district hospital" is defined as a hospital that meets all of the following requirements:
    - Is a district hospital organized and governed pursuant to the Local Healthcare District Law.
    - Provides a percentage of care to Medicare, Medi-Cal, and uninsured patients that exceeds 50 percent of patient days.
    - Is located in a county with a total population of less than 750,000. (According to the 2000 Census, the following counties have a population over 750,000; therefore, hospitals in these counties are not eligible to participate in the pilot: Alameda, Contra Costa, Fresno, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.)
    - Has net losses from operations in fiscal year 2000-01, as reported to the Office of Statewide Health Planning and Development.

- The participating hospital is prohibited from interfering with, controlling, or otherwise directing the physician's professional judgment.

- The medical staff and the elected trustees of the qualified district hospital concur by an affirmative vote of each body that the physician's employment is in the best interest of the communities served by the hospital.

- The physician enters into or renews a written employment contract with the qualified district hospital prior to December 31, 2006, for a term not in excess of four years, and the employment contracts provide for mandatory dispute resolution under the auspices of the Board for disputes directly relating to the physician's clinical practice.

- The qualified district hospital must notify the Board in writing that the hospital plans to enter into a written contract with the physician; the Board must provide written confirmation to the hospital within five working days of receipt of the written notification to the Board.

- The board shall report to the Legislature not later than October 1, 2008, on the evaluation of the effectiveness of the pilot project in improving access to healthcare in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine.

**Legislative Intent of the SB 376 Pilot**

In crafting the actual bill language of SB 376, the Legislature added the findings and declarations to support the intent of the bill:

- Due to the large number of uninsured and underinsured Californians, a number of California communities are having great difficulty recruiting and retaining physicians and surgeons.

- In order to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities, many district hospitals have no viable alternative but to directly employ physicians and surgeons in order to provide economic security adequate for a physician and surgeon to relocate and reside in their communities.

- The Legislature intends that a district hospital meeting the conditions set forth in this section be able to employ physicians and surgeons directly, and to charge for their professional services.

- The Legislature reaffirms that Section 2400 provides an increasingly important protection for patients and physicians and surgeons from inappropriate intrusions into the practice of medicine, and further intends that a district hospital not interfere with, control, or otherwise direct a physician and surgeon's professional judgment.

**Typical Recruitment Process**

*[Staff is in the process of contacting the Human Resources Team at the participating hospitals to elucidate on the typical recruitment process used to secure the services of a physician using the traditional contracting process compared to the process used to employ a physician under the SB 376 pilot.]*

**Evaluation of the Pilot**

To evaluate the effectiveness of the pilot in improving access to healthcare in rural and medically underserved areas, and the pilot's impact on consumer protection as it relates to intrusions into the practice of medicine, the Board was directed to report to the Legislature no later than October 1, 2008, on the outcome of the pilot.

While SB 376 was being debated before the Legislature, the Board discussed the potential impact of the bill with the author's office. While recognizing that the limitations of the pilot (a statewide total of 20 participants with no more than two physicians at any one hospital) would make only a small first-step towards increasing access to healthcare, the Board anticipated that all 20 slots soon would be filled. After the Governor signed the bill and the law took effect on January 1, 2004, staff was prepared to promptly process the applications as they were submitted. The Board recognized that in order to have an adequate base of physicians to use in preparing a valid analysis of the pilot, as many as possible of the 20 positions would need to be filled.

Unexpectedly, the first application was not received until six months after the pilot became operational, and that hospital (Chowchilla District Memorial Hospital) elected to hire a physician for only three years instead of the four years allowed by the pilot. Further, during the life of the pilot, only six physicians were hired by five eligible hospitals; the Board was concerned that such a low number would not offer a significant, quantifiable improvement in access to healthcare nor would such a low number offer much information to the Board in preparing a valid and useful analysis of the pilot.

The following chart includes the names of the five participating hospitals and the contract period for each of the six participating physicians:

| Name of Hospital: | Physician's Contract Period: |
|---|---|
| Chowchilla District Memorial Hospital | June 14, 2004 - June 13, 2007 |
| Kaweah Delta Healthcare District | August 16, 2004 - August 15, 2008 |
| John C Fremont Healthcare District | February 1, 2005 - February 1, 2009 |
| Pioneers Memorial Healthcare District | April 15, 2005 - April 14, 2009 |
| Pioneers Memorial Healthcare District | December 15, 2005 - December 14, 2009 |
| Mendocino Coast District Hospital | March 24, 2006 - March 23, 2010 |

Throughout the life of the pilot, periodic contact was made by the Board's staff with the administrators of the participating hospitals, seeking input on the effectiveness of the pilot. However, the administrators offered limited comments, mainly that they were pleased with the physicians' service to patients and that the pilot had been instrumental in bringing the physicians to work in the hospitals.

During December, 2006, the Board sent letters to the participating physicians and to the administrators of the participating hospitals, asking each to start thinking about the effectiveness of the pilot, with a reminder that input from each was essential to the Board's analysis.

In early-2008, the Board sent letters to the same participants, asking each to define the successes, problems (if any), and overall effectiveness of this pilot for the hospital and on consumer protection. The administrators were asked for input as to how the pilot could be strengthened.

Around the same time, the Board sent letters to the hospital administrators on the list of all ACHD members, whether or not the hospital was eligible to participate in the pilot. If the hospital was eligible, the administrators were queried as to why they did you not participate in the pilot. If the hospital was not eligible, the administrators were asked if they would have participated in the pilot if they had been eligible The letter asked what changes could have been made to improve the pilot and if the pilot would have had an impact on access to care in that area?

(A copy of each of the 2008 outreach letters will be included at the end of this report.)

Despite follow-up faxed requests and phone calls, the response to the Board's letters was limited. Four of the six participating physicians replied and staff conducted a site visit with two of the six participants; and the administrators of only three of the five participating hospitals replied. The following is a summary of the replies; physicians are not listed in any particular order.

**Comments Submitted by Participating Physicians**

**Physician #1:** This family practice physician was recruited from out of state, where she worked in a hospital; she moved to California only for the purpose of accepting this offer of employment. While not addressing the benefits or drawbacks of the pilot, this physician indicated that "without the program, it would not have been able for [the hospital] to recruit and retain a physician like me." However, this physician left the position almost two years before the end of the employment period and returned to her home state to accept a position in a different hospital.

**Physician #2:** This oncologist was working in Northern California for a major healthcare organization, but moved to a location several hours away to accept this offer of employment.

This physician offers specialty care that previously was not available to residents without driving two to four hours, thus saving time and gas money for the patients and allowing them to remain

close to their support community. The physician indicated that this specialty care is difficult to offer as a solo-practitioner in rural areas due to the need for extensive medications, treatments, and equipment, which incur exorbitant start-up fees; however, these are resources that a hospital can more easily provide.

This physician deemed the pilot an unqualified success. Since the pilot is scheduled to sunset, and the employment contract is scheduled to end, this physician indicated the intent to find employment elsewhere.

This physician indicated that a reasonable and stable salary was beneficial to his personal circumstances. However, he stated that he believed the pilot had too many restrictions to be successful in its goals; specifically, each condition which determined that a district hospital was not eligible to participate in the pilot was an impediment to increased health care.

**Physician #3:** This psychiatrist was working in a neighboring county before accepting this offer of employment; he had been offering his services through a public agency. This physician is one of the few who practices this specialty in the area and offers these services primarily to children and adolescents. Previously, many patients had difficulty getting access to this specialty care.

This physician commented that while many physicians are willing to work in underserved areas, they are looking for employment instead of contracted positions. This physician also commented that since many physicians are already employed by public agencies in California, these employment opportunities should be extended to hospitals.

He continues to see patients at a local mental healthcare clinic and is on the instructional staff at a nearby teaching hospital.

**Physician #4:** This internist identified himself as being in his late-60s. Having worked in private practice (in the same city as the employing hospital) for over 30 years, he already had a significant patient population but had grown frustrated with the business aspects of the traditional private practice model. Being employed by the hospital allowed him to continue offering healthcare service in the area and, through a special billing arrangement with the hospital, he could provide in-patient care to his original patients.

This physician commented on the benefits offered to him as an employee: less expensive insurance (personal health, dental, and malpractice), the opportunity to participate in a 401k fund, and numerous other retirement benefits.

Further, being employed by the hospital alleviated several items to which he would have been obligated in private practice, such as the costs to lease office space and the need to maintain tail-end insurance coverage.

**Physician #5:** This internist already was living in the city when he was hired. Before being hired, he was working in a medical group but was considering a move out of the area. However, this program was the catalyst which retained him in the area.

Being hired by the hospital allowed him to concentrate on a specialty in which he previously had worked and enjoyed. His new position with the hospital allowed patients to receive a continuity of care by one physician instead of various physicians rotating through the clinic. But most importantly, the employment of this physician allowed for local health care, instead of having the patients drive several hours for this care, which often had been the only option.

**Physician #6:** There was no reply to the survey from this physician. However, it was determined that this family practice physician already was living in the city when hired. The employment period has ended and this physician went to work in a local community clinic.

**Comments Submitted by Administrators of Participating Hospitals**

**Chowchilla District Memorial Hospital:** There was no reply to the survey from this hospital.

**John C. Fremont Healthcare District:** There was no formal reply to the survey from this hospital. However, subsequent email communications with hospital staff indicate that within a short period after the physician's departure, the hospital entered into a traditional contract with another physician for services left by the vacancy.

**Kaweah Delta Hospital:** This administrator pointed out that physicians are employed by many public agencies throughout California; further, this practice is legal in many states. In addition, he stated that healthcare districts are the only public agency in California not allowed to employ physicians, something worthy of changing.

Many of the physicians currently working at this hospital are planning to retire soon, and recruiting and retaining new physicians is a problem due to lack of job security. Employment opportunities would address that concern. However, being able to hire only one or two physicians under the pilot does not address the real need.

There were no problems with the physician who was employed; there were no consumer protection issues. This physician filled a need in the community for care in this specialty.

**Mendocino Coast District Hospital:** The hospital administrator stated that this physician would not have come to this area if not hired as an employee. This physician has been instrumental in the development of a specialty clinic and treatment center, a tremendous asset to both the hospital and community.

This physician's presence in the community increased access to care in this rural community; the patients in need of this specialty care were able to receive local care, which was previously not available.

In support of the pilot, the administrator said that the ability to employ physicians allows for greater clinical integration between hospitals and physicians.

**Pioneers Memorial Hospital:** This hospital hired two physicians. With the addition of the first physician to the staff, the hospital was able to open a new primary care clinic, which then expanded to include an after-hours urgent care center. This facility has 9,000 patient visits annually, mainly Medi-Cal patients. This facility is also designated as a Rural Health Center.

Hiring the second physician allowed expanded services to the business community via the only hospital-based Worker's Compensation Clinic in the area, which was previously served only a few hours a week by three part-time physicians. This facility works with over 600 businesses; these services have greatly improved back-to-work time, which increased productivity in the community and have allowed patients to see local physicians instead of having to drive about two hours, as previously necessary. There seems to be greater patient satisfaction by having the continuity of care by one physician who is always available; further, by operating the clinic full-time, the hospital has been able to justify upgraded facilities.

This administrator indicated that improved recruitment packages offering employment might be a vehicle to attract new physicians to the area. However, the two physicians actually hired under SB 376 already were living and working in the area and this program was used as a method of retention, so neither would retire or move away.

Having these two additional physicians has improved long-term viability of the hospital, a facility at which the vast majority of current physicians are looking at probable retirement in the next five to 10 years.

Lastly, the accounting staff at the hospital has commented that the paperwork for an employed physician is significantly less than the billing paperwork required for a contracted physician.

Normally, this hospital recruits new physicians using "head hunting" firms. However, both of the physicians hired under the pilot were personally known to the hospital administrator.

**Comments from non-Participating Hospitals**

Administrators from six of the non-participating hospitals communicated with the Board in reply to the letters sent. They agreed that the pilot seemed worthwhile in addressing the shortage of health professionals. They offered a variety of comments:

- The hospital administration supported the pilot but the medical staff did not approve a motion to hire a physician. Senior physicians saw it as a threat and believed that new physicians should "pay their dues."
- Employment of physicians could benefit the hospital.
- Most physicians want the security that comes with employment, not just a contract.
- Most physicians who leave the hospital go out of state for employment opportunities.
- One hospital wanted to offer employment opportunities to physicians currently on contract instead of hiring a new physician; however, so as not to show favoritism, they decided not to hire anyone.
- The three-year *[sic]* contracting limit in the pilot was a barrier; no one would want to give up private practice with uncertainty over job security.
- One hospital is located in a county with a population higher than the pilot's threshold; otherwise, would have tried to hire someone.
- Past recruitment has been difficult; recruiting firms indicate the greatest barrier is the lack of employment.
- Other public agencies can hire physicians, which should be extended to district hospitals.

One hospital administrator replied that the hospital has no interest in directly employing physicians. In his opinion, traditional contracts provide the services of a physician at a lower cost to the hospital and, he believes, a greater level of satisfaction to the physician.

Letters to three hospitals were returned because the facility was closed or the district no longer operated the hospital.

**Conclusions**

During the past years, discussions with numerous stakeholders, even beyond those participating in this pilot, continuously highlight that the availability of healthcare professionals is greatly lacking in California. Addressing improved access to healthcare is one of the goals of the SB 376 pilot.

From the responses received to the Board's queries about the pilot, there seems to be a universal belief that many physicians hesitate settling in California, especially rural areas of the state, because of the disincentive created by the laws governing the corporate practice of medicine—most physicians in California work as contractors, not employees. Hospital administrators view the prohibition of the corporate practice of medicine as complicating their ability to ensure adequate staffing. This is further exacerbated by contractors not realizing the same work-related benefits as an employee.

Admittedly, any one additional healthcare provider who offers services is going to increase access to healthcare, regardless of how minimally. And it is obvious from the responses received, that the six physicians who were employed under the pilot provided additional access to healthcare to the residents of their service area; some of the physicians offered specialty services not otherwise available, an even greater benefit.

Yet the Board regrets that there was not a larger pool of participants from whom to gather data which would allow for a more in-depth analysis. The potential of collecting data from only six physicians and five hospital administrators created a challenge. The fact that responses were provided from only three of the five participating hospitals and five of the six participating physicians further inhibits the potential for a valuable analysis.

Therefore, the Medical Board believes there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians can be made.

State of California

Department of Consumer Affairs

# Memorandum

To: Renée Threadgill, Chief of Enforcement
Medical Board of California

Date: July 1, 2008

From: Susan Goetzinger
Expert Reviewer Program

Subject: Results of the Expert Survey Questionnaires

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| Questionnaires Sent this quarter (April 1-June 30, 2008) | 44 |
| Feedback Received from the questionnaires sent this quarter | 33 (75 percent) |
| Total Feedback Received for this quarter's report | 36 |

Questions 1-9, *positive response*: Yes
Question 10, *positive response*: No
Questions 11, *positive response*: Yes
Questions 12-14, *positive response*: Yes

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| 1 | Were you provided sufficient information/evidence to allow you to render a medical opinion? | 100 percent YES |
| 2 | Were you encouraged to render an unbiased opinion? | 100 percent YES |
| 3 | Was the case directly related to your field of expertise? | 100 percent YES |
| 4 | Were you given sufficient time to review the case? If not, how much time would have been appropriate for this review? | 94 percent YES<br>6 percent NO |
| | *No response-suggested 60* days | |
| 5 | Did the MBC staff meet your expectations to provide you with what you needed to complete your review? If no, what should have been provided to facilitate your review? | 97 percent YES<br>3 percent did not respond |
| 6 | Did the training material provided to you (the Expert Reviewer Guidelines and videotape/DVD) give you adequate information to perform your case review? | 97 percent YES<br>3 percent responded N/A |
| 7 | Were you given clear, concise, and easy to follow instructions throughout the process? | 97 percent YES<br>3 percent responded N/A |
| 8 | Was the investigator and/or MBC staff readily available to answer questions or concerns about the case? | 100 percent YES |
| 9 | Is the required written report adequate to cover all aspects of your opinion? | 97 percent YES<br>3 percent responded N/A |

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| 10 | Do you feel the MBC has requested your services more frequently than you would prefer? | 97 percent NO<br>3 percent responded N/A |
| 11 | Would you be willing to accept more MBC cases for review? | 100 percent YES |
| 12 | If you were required to testify, was the Deputy Attorney General readily available to answer questions and provide direction? | 8 percent YES<br>92 percent N/A |
| 13 | Did the Deputy Attorney General or his/her representative meet your expectations to provide you with what you needed prior to testifying? If no, what would have made testifying for the Board easier? | 94 percent N/A<br>6 percent YES |
| 14 | Do you feel the reimbursement amount for case review is appropriate for the work you are required to perform? | 66 percent YES<br>25 percent NO<br>6 percent N/A<br>3 percent did not respond |
| *Level of satisfaction with overall experience performing case reviews for MBC* | | 83 percent HIGH<br>14 percent AVERAGE<br>3 percent did not respond |

## SUGGESTIONS FOR IMPROVEMENT TO THE PROGRAM

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| The ability to dictate my reports would have been nice. Hand typing the reports is time consuming and adds expense to the review. |
| There should be a middle rating - simple, *moderate...*<br><br>There was some discrepancy between the material I received re assigning the assessment from the Board & in the material I received re the actual case. |
| Realize that many times more records are needed and this may make the "30-day" due date harder. |
| Increase reimbursement.<br><br>If possible, decrease time needed to get complete medical records-ask reviewers what parts of records are really needed to render quick reporting turnaround. Obtaining the proper records is the rate-limiting step in reporting. |

## COMMENTS REGARDING REIMBURSEMENTS

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| Specialists want to help with this important public service, but the current rate of $150 may not be sufficient to attract additional specialists for these reviews. For background & to help with your planning, most of my colleagues who provide case reviews, consultation or testifying service generally charge hourly rates of $350-450. |

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| Reimbursement could be higher - most medical expert case analysis average $400-600/hr and then more if required to appear, so this is really a public service which I feel is important to protect the public. |
| $200/hr more reasonable as subspecialist expert |
| $150/hr is appropriate, but review + report required longer time than anticipated. *(spent over 10 hrs, but only charged 10)* |
| The reimbursement rate is low. For private medical legal cases I do, I charge $300 for chart review & research $500 for depos & testimony. |

**GENERAL COMMENTS**

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| Superb support. |
| I am happy to do medical reviews. |
| I thoroughly enjoy reviewing cases for the MBC. I welcome reviewing future cases. It is a delight and pleasure working with everyone from MBC. |
| Both Dr. Snider & Ms. Holloway were readily available and responsive to questions and requests. |
| I would prefer that the MBC requested my services more frequently |
| No suggestions for improvement, first review went very well.<br><br>Given the high volume of records to review in this case, and the subsequent lengthy report, the expectation that work be accomplished in 10 hours or less was unrealistic. |
| I feel under utilized which hopefully means few radiology cases are occurring.<br><br>Regarding reimbursement rate, I have very little free time and when I do such reviews for medical cases, I charge more per hour for my time. That being said, I believe so strongly in peer review that I would gladly review MBC cases for No Fee. I believe that if the physicians do not do this, then someone less informed will, by default.<br><br>I am very impressed with the effort spent and quality of work product in the investigation and data collection of MBC cases. Thank you for the opportunity to participate. |
| would be of great help to reviewers if the records are in chronological order as much as possible |

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| I really enjoy document review. I think $150/hr is low but at present fair fee - appropriate because I see my reviews in part as an aspect of public service. It is necessary. I have seen more patients die or put at real risk in my 2 years in LA than in 25 years in Wash. DC. I think the review process could be improved - i.e. made more efficient - & I'd be happy to take part in discussions as to how this might be done.<br><br>I think the Investigators are very professional, dedicated & do an excellent job. |
| I'm always willing to review cases if appropriate to my specialty, so keep them coming!<br><br>Thanks for the opportunity to participate in the program. It is interesting, I always learn a lot and hope I'm helping to contribute to patients safety. The investigators have been really helpful! |
| I am always impressed with the investigative reports from your staff. Marybeth Rodriguez is delightful to work with. |
| Excellent support with Medical Board! |

## CASES BY SPECIALTY SENT FOR REVIEW
## USE OF EXPERTS BY SPECIALTY
## ACTIVE LIST EXPERTS BY SPECIALTY

Calendar Year (2008)

| SPECIALTY | Number of cases reviewed/sent to Experts Jan-June 2008 | Number of Experts used and how often utilized Jan-June 2008 | Active List Experts Y-T-D (TOTAL= 1,173 ↑) |
|---|---|---|---|
| ADDICTION | | | 11 |
| AEROSPACE MEDICINE | | | 1 |
| ALLERGY & IMMUNOLOGY | | | 10 |
| ANESTHESIOLOGY | 11 | 9 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 90 |
| BIOETHICS | | | 1 |
| COLON & RECTAL SURGERY | | | 5 |
| COMPLEMENTARY/ALTERNATIVE MEDICINE | | | 13 |
| CORRECTIONAL MEDICINE | 5 | 2 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 3 CASES | 11 ↑ |
| DERMATOLOGY | 5 | 3 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 12 |
| EMERGENCY | 14 | 13 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 63 ↓ |
| ETHICS | 1 | 1 LIST EXPERT | 2 ↑ |
| FAMILY | 26 | 21 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES<br>1 LIST EXPERT REVIEWED 3 CASES | 97 |
| HOSPICE & PALLIATIVE CARE | | | 7 |
| INTERNAL<br>General Internal Med & sub-specialties not listed below | 29 | 24 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES<br>1 LIST EXPERT REVIEWED 3 CASES | 238 ↑ |
| INTERNAL - CARDIOLOGY<br>Interventional Cardiology | 7 | 7 LIST EXPERTS | 35 ↑<br>[23↑] |
| INTERNAL-ENDOCRINOLOGY & METABOLISM | | | 9 |
| INTERNAL - GASTROENTEROLOGY | | | 18 |
| INTERNAL -INFECTIOUS DISEASES | | | 10 |
| INTERNAL - NEPHROLOGY | | | 8 |
| INTERNAL - ONCOLOGY | | | 13 ↑ |
| MEDICAL GENETICS | | | 1 |
| MIDWIFE | | | 12 |
| NEUROLOGICAL SURGERY | 4 | 2 OUTSIDE EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 15 |
| NEUROLOGY | 1 | 1 LIST EXPERT | 20 ↓ |

**CASES BY SPECIALTY SENT FOR REVIEW**
**USE OF EXPERTS BY SPECIALTY**
**ACTIVE LIST EXPERTS BY SPECIALTY**
(CALENDAR YEAR TO DATE : JAN-JUNE 2008)
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|---|---|---|---|
| NEUROLOGY (CHILD) | | | 5 ↑ |
| OBSTETRICS & GYNECOLOGY | 20 | 11 LIST EXPERTS REVIEWED 1 CASE<br>3 LIST EXPERTS REVIEWED 2 CASES<br>1 LIST EXPERT REVIEWED 3 CASES | 89 ↑ |
| REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY | | | 6 ↑ |
| OCCUPATIONAL MEDICINE | 1 | 1 LIST EXPERT | 8 |
| OPHTHALMOLOGY | 7 | 7 LIST EXPERTS | 49 |
| ORAL & MAXILLOFACIAL SURGERY | | | 1 |
| ORTHOPAEDIC SURGERY | 14 | 10 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 3 CASES & 1 SUPPLEMENTAL REVIEW | 49 |
| OTOLARYNGOLOGY | 2 | 2 LIST EXPERTS | 33 |
| PAIN MEDICINE ((18ABMS↑; 12 ABPM = 31) | 8 | 2 LIST EXPERTS REVIEWED 1 CASE<br>3 LIST EXPERTS REVIEWED 2 CASES | 26 ↓ |
| PATHOLOGY (Anatomic/Clinical-12; Anatomic-1) | 1 | 1 LIST EXPERT | 13 |
| PEDIATRICS | 1 | 1 LIST EXPERT | 66 ↑ |
| PEDIATRIC CARDIOLOGY | 1 | 1 LIST EXPERT | 5 |
| PEDIATRIC CARDIOTHORACIC SURGERY | 1 | 1 LIST EXPERT | 2 ↑ |
| PEDIATRIC HEMATOLOGY/ONCOLOGY | | | 5 |
| PEDIATRIC INFECTIOUS DISEASES (BOARD CERTIFIED) | | | 3 |
| PEDIATRIC SURGERY | | | 2 ↓ |
| PHYSICAL MEDICINE & REHABILITATION | | | 9 ↓ |
| PLASTIC SURGERY | 13 | 11 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 50 ↑ |
| PSYCHIATRY | 34 | 25 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES<br>1 LIST EXPERT REVIEWED 3 CASES (1 CASE REVIEW, 2 MENTAL EVALS)<br>1 LIST EXPERT REVIEWED 4 CASES (1 CASE REVIEW, 2 MENTAL EVALS, 1 PREP & TESTIMONY) | 111 ↓ |
| PUBLIC HEALTH & GENERAL PREVENTIVE MEDICINE | | | 6 |
| RADIOLOGY (3↓) DIAGNOSTIC RADIOLOGY-32 ↑<br>NUCLEAR MEDICINE-6 | 9 | 4 LIST EXPERTS REVIEWED 1 CASES<br>1 LIST EXPERT REVIEWED 5 CASES<br>(name flagged from database) | 35 ↓ |
| VASCULAR/INTERVENTIONAL RADIOLOGY (Board Certified) | | | 2 |
| RADIATION ONCOLOGY -4 /<br>THERAPEUTIC RADIOLOGY -2 | | | 6 |

**CASES BY SPECIALTY SENT FOR REVIEW**
**USE OF EXPERTS BY SPECIALTY**
**ACTIVE LIST EXPERTS BY SPECIALTY**
(CALENDAR YEAR TO DATE : JAN-JUNE 2008)


| | | | |
|---|---|---|---|
| SLEEP MEDICINE | | | 8 |
| SPINE SURGERY (ABSS-MBC APPROVED) | | | 1 |
| SURGERY | 9 | 7 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 60 ↑ |
| THORACIC SURGERY | 6 | 6 LIST EXPERTS | 20 ↑ |
| VASCULAR SURGERY | 1 | 1 LIST EXPERT | 6 |
| UROLOGY | 5 | 3 LIST EXPERTS REVIEWED 1 CASE<br>1 LIST EXPERT REVIEWED 2 CASES | 17 |
| WORKERS' COMP/QME/IME | | | 8 ↑ |

/susan (6/30/08)